US Decisions Inc.

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DATE NOTICE SENT TO ALL PARTIES: Apr/15/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 80 hrs Chronic Pain Management Body Part: Lumbar Spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, Board Certified Physical Medicine and Rehabilitation.

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of the reviewer that the request for 80 hrs Chronic Pain management Body Part: Lumbar Spine is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is XX/XX/XX. The patient was on top of a tanker truck when the spinner slipped and he reached for it and felt sharp pain in the lower back. The patient underwent caudal epidural steroid injection on XX/XX/XX. The patient underwent lumbar spine laminectomy and microdiscectomy on XX/XX/XX. Functional capacity evaluation dated XX/XX/XX indicates that required PDL is medium-heavy, and current PDL is sedentary light. Behavioral health evaluation dated XX/XX/XX indicates that the patient presents with a moderate level of depression and anxiety. BDI is 28 and BAI is 16. FABQ-PA is 24 and FABQ-W is 42. Diagnosis is chronic pain disorder.

Initial request for 80 hours of chronic pain management was non-certified on XX/XX/XX noting that the medical notes show that the patient is at MMI. In comparing the follow up current examinations, the patient examination findings are staying consistent and no changes in over a year. The ODG guidelines indicate that if the patient has been continuously disabled for greater than 24 months, the outcomes for the necessity of use of the chronic pain management should be clearly identified. The functional capacity evaluation shows that the patient is performing at light PDL and there is conflicting evidence I the medical notes of the patient's PDL light-medium or medium-heavy. Letter of reconsideration dated XX/XX/XX indicates that all lower levels of care have been exhausted per ODG at this point. The functional capacity evaluation dated XX/XX/XX is noted to show that the patient is able to perform at a sedentary-light PDL and required PDL is medium-heavy. The denial was upheld on appeal dated XX/XX/XX noting that the functional capacity evaluation indicated that the patient was performing at a light PDL, conflicting with the medical reports of light to medium, or medium to heavy PDL. The length of time off from the injury was also noted, with poor outcomes due to that length of disability.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on XX/XX/XX and was subsequently treated with injection therapy, surgical intervention and postoperative physical therapy. The Official Disability Guidelines generally do not recommend chronic pain management programs for patients who have been continuously disabled for greater than 24 months as there is conflicting evidence that these programs provide return to work beyond this period. There is no documentation of any recent active treatment. The submitted records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. There is no indication that the patient has undergone any lower level psychological treatment. As such, it is the opinion of the reviewer that the request for 80 hrs Chronic Pain management Body Part: Lumbar Spine is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)